

## Pharmacy Conversion *Member Input Form*

Please provide the information requested below in preparation for documenting your choices in the various Pharmacy programs available through Premier contracted suppliers. The information on this form will be used to auto-populate the many forms in the Performance Program (LOC, LOP, etc.), Declarations, and if applicable, Auto-Sub and DSH.

The form fields will be filled in based on the information you supply here. This DOES NOT activate or imply approval of any of the agreements or commitments. You will have the opportunity to review and officially sign only the documents that you choose.

<b>New GPO:</b>	<b>Effective Start Date:</b>	<b>Previous GPO:</b>
PREMIER HEALTHCARE ALLIANCE, L.P.		Premier

<b>Facility Name:</b>	<b>System Name:</b>
Mangum Regional Medical Center	Cohesive Healthcare Management

<b>Member Address:</b>	<b>Address Line 2:</b>
1 Wickersham Drive	

<b>City:</b>	<b>State:</b>	<b>Zipcode:</b>
Mangum	Oklahoma	73554

<b>DEA:</b>	<b>HIN:</b>	<b>DSH ID:</b>	<b>Entity Code:</b>	<b>Class of Trade:</b>
FM7151777	730710IF2		834641	Acute Hospital

**Pharmacy Authorized Signee:**

<b>Name:</b>	Carson VanZant
<b>Title:</b>	Chairman of Board
<b>Fax:</b>	
<b>Phone:</b>	(580) 782-3353
<b>Email:</b>	kmartinez@chmcok.com

**Distributor / Wholesaler:**

<b>Name:</b>	AmerisourceBergen
<b>City:</b>	
<b>State:</b>	
<b>Zip:</b>	

<b>Other Notes:</b>	
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Please submit this form via e-mail upon completion. Thank-you for your participation and please ask your Premier contact if you have any questions throughout the process.

SELLER: Amgen USA Inc.  
CONTRACT NUMBER: PPPH18AMG04 (Amgen #00106268)  
PRODUCT CATEGORY: Brand Pharmaceuticals

**Exhibit J**  
**Amgen Eligible Member Declaration Form**



Member Name: Mangum Regional Medical Center Cohesive Healthcare Management

Address: 1 Wickersham Drive

City: Mangum, State: Oklahoma, Zip: 73554

HIN # 730710IF2 or Other ID #: FM7151777

**\_\_\_\_\_ this is an Affiliate** (An Affiliate of an entity on contract with Amgen, is an entity that controls, is controlled by, or under common control with such given entity. "Control" shall mean ownership of more than fifty percent (50%) of the voting stock of an entity or, for non-stock entities, the right to more than fifty percent (50%) of the profits of such entity); **please specify the nature of affiliation and list affiliates on attached page.**

Dear Premier Member:

Premier Healthcare Alliance, L.P. ("Purchasing Group") has recently entered into a Group Purchasing Organization Agreement with Amgen, Agreement No. PPPH18AMG04 ("GPO Agreement") for availability of discounts and rebates for Purchasing Group's members on purchases of Amgen Product from Authorized Wholesalers. In order to participate under the GPO Agreement, please certify your request to be eligible for discounts on purchases of Amgen Product exclusively through Purchasing Group under the GPO Agreement by signing below. If you currently are eligible for discounts on purchases of Amgen Product through another group purchasing organization, you must terminate your affiliation with that group purchasing organization for your discounts on purchases of Amgen Product and agree to only participate in the eligibility for discounts on purchases of Product through Purchasing Group pursuant to the terms and conditions of the GPO Agreement. If you currently are eligible for discounts on purchases of Amgen Product through another agreement with Amgen, you are hereby terminating that agreement and agree to only participate in eligibility for the discounts on purchases of Amgen Product during the GPO Agreement term through Purchasing Group pursuant to the terms and conditions of the GPO Agreement. You will be required to execute a new Declaration Form for any change in your affiliation and each time a change in your affiliation occurs, for such change in your affiliation to be recognized by Amgen. If you have no current affiliation with a GPO, upon receipt of your executed Declaration Form by the Amgen Membership Department, the effective date of your requested change shall be as soon as practicable for Amgen and such effective date shall be disclosed in writing by Amgen to your Purchasing Group in advance of such effective date. All other requested affiliation changes will be effective thirty (30) days after your executed Declaration Form is received by the Amgen Membership Department, unless Amgen notifies your Purchasing Group in writing of a later date.

**Declaration**

On behalf of Member Name: Mangum Regional Medical Center ("Member") and its affiliates, the undersigned agrees to and certifies the following:

- 1) Member agrees to only participate in the eligibility for discounts on purchases of Amgen Product through Purchasing Group pursuant to the terms and conditions set forth in the GPO Agreement, unless Amgen is provided thirty (30) days written notice of Member's desire to discontinue participation under the GPO Agreement;

SELLER: Amgen USA Inc.  
CONTRACT NUMBER: PPPH18AMG04 (Amgen #00106268)  
PRODUCT CATEGORY: Brand Pharmaceuticals

- 2) Member hereby declares that it will not participate in the eligibility for discounts on purchases of Amgen Product under any other affiliation agreement or arrangement and will not avail itself of the discount and rebate terms on purchases of Amgen Product pursuant to any other agreement;
- 3) Member agrees that it will purchase Amgen Product from Authorized Wholesalers only for its “own use” in its hospital/office(s) for the exclusive treatment of its patients and shall not transfer Amgen Product made available pursuant to the terms of the GPO Agreement to any person or entity or to any third party other than the end user patient, nor make the terms set forth in the GPO Agreement available to or for the benefit of any person other than Member;
- 4) Member acknowledges and agrees that Member shall provide Amgen and [membership@amgen.com](mailto:membership@amgen.com) with notice of any changes to Member’s information including the addition of any affiliate hospitals or the removal of any closed affiliate hospital and/or the removal of affiliate hospitals with no patients no less than thirty (30) days prior to the effective date of such change;
- 5) Member shall provide Amgen with written notice of any changes to the Control, as defined in this Declaration Form and in the GPO Agreement, for either the member or its affiliates. Member must provide Amgen notice by email notification transmitted to [membership@amgen.com](mailto:membership@amgen.com) within thirty (30) days after the effective date of such change; and
- 6) The undersigned has the full power and authority to execute this Declaration on behalf of Member and its legal affiliates. A list of Member’s legal affiliates that will participate under the GPO Agreement, including name, address, phone number and Health Industry Number (HIN) has been attached to this Declaration Form.

Signature: \_\_\_\_\_

Print Name: Carson VanZant

Print Title: Chairman of Board

Date: \_\_\_\_\_

HIN or other ID: 730710IF2 FM7151777

Email to: Amgen Membership at [membership@amgen.com](mailto:membership@amgen.com) with copy to [Rosters@Premierinc.com](mailto:Rosters@Premierinc.com) (Attn: Premier/Amgen Declaration Form)

# EXHIBIT Q

## AstraZeneca Pharmaceuticals LP

### Group Purchasing Organization Declaration Form

To comply with the AstraZeneca Single Dedication Policy, please accept this declaration that  
Mangum Regional Medical Center Cohesive Healthcare Management

(Facility Name)

- A. (profit) or (non-profit as defined under 26 U.S.C. 501(c)(3)) Hospital  
 LOKELMA Discharge Protocol / Discharge Order Set Eligible
- B. (profit) or (non-profit) organization that maintains a closed-door pharmacy (no retail affiliation or sales to the general public) or a combination Pharmacy (segregated inventories for retail and closed-door pharmacy)
- ("Facility") is declaring PREMIER HEALTHCARE ALLIANCE, L.P.  
as the exclusive Group Purchasing Organization ("GPO") for contract eligibility with AstraZeneca.

This document serves as written confirmation of the exclusive GPO of choice by Facility and will remain in effect and on file until further written confirmation of a change has been received and approved by AstraZeneca. AstraZeneca, as referred to herein, shall mean AstraZeneca Pharmaceuticals LP, ("AZPLP"), for all Products identified by an AZPLP product code, labeler code or NDC number. References to AstraZeneca Products herein shall refer to AZPLP Products. Facility agrees to permit AstraZeneca to audit annually, on reasonable notice and during normal business hours, all books and records of the undersigned related to any AstraZeneca Products purchased by Facility. Facility certifies that all data submitted by Facility to the exclusive GPO of choice or to AstraZeneca for chargebacks and other reimbursements relating to purchases by Facility under the AstraZeneca contract with the exclusive GPO of choice (the "Agreement") must be data originating from purchases of U.S. AstraZeneca Product bearing an AstraZeneca 11-digit National Drug Code, as assigned by the U.S. Food and Drug Administration. In addition, all applicable federal and state laws must be adhered to. Facility also certifies that (i) Facility's pharmacy(ies) that dispenses AstraZeneca Products that are the subject of the Agreement are located, licensed and registered within the United States of America; (ii) AstraZeneca Products purchased under the AstraZeneca contract with the exclusive GPO of choice are for its "own use," and no products purchased under the Agreement may be commercially resold or redistributed to any other entity or person. Sales and/or redistribution of said products to any other type of entity, account or third party will be a violation of such contract and, in addition to pursuing any other remedies that AstraZeneca may have available at law or equity, AstraZeneca may terminate your right to receive products and/or reimbursements under said contract. AstraZeneca reserves the right to terminate Facility's Authorized Membership if at any time it is discovered by AstraZeneca that (i) Facility is generating duplicate utilization (i.e., the Facility has received reimbursement for such utilization through a Separate Agreement in addition to the GPO Discount Agreement), or (ii) AstraZeneca discovers that Facility does not meet the definition of their declared Class(es) of Trade.

**THIS SECTION IS NOT APPLICABLE TO HOSPITALS:** Please check  the box which best describes your facility:

- |  |   |
|--|---|
| <input type="checkbox"/> Clinic Non-Dispensing Oncology Clinic   | <input type="checkbox"/> Physician/Practitioner   |
| <input type="checkbox"/> Home Health/Home Infusion   | <input type="checkbox"/> Self-Dispensing Oncology Clinic (has on-site pharmacy or dispensary) |
| <input type="checkbox"/> Hospice HMO Facility  | <input type="checkbox"/> Rehabilitation Facility  |
| <input type="checkbox"/> Long Term Care Facility (Nursing Home/Nursing Home Provider)  |   |
| <ul style="list-style-type: none"> <li>Nursing Home Provider – Sales of products purchased are limited to licensed nursing homes, approved correctional facilities and other long-term care facilities for their own use.</li> </ul>   |   |
| <input type="checkbox"/> Combination Pharmacy (Closed Door/Retail)   |   |
| <ul style="list-style-type: none"> <li>Combination Pharmacy is defined as a pharmacy with segregated inventories for retail and closed-door within the same facility. A retail &amp; closed-door DEA, HIN, or Wholesaler ID must be provided to show separation of retail from closed-door inventory.</li> </ul> |   |

and/or

\_\_\_\_\_  
(Retail DEA/ HIN Number)

\_\_\_\_\_  
(Retail Wholesaler Acct #) and/or

\_\_\_\_\_  
(Closed-door DEA or HIN#)

\_\_\_\_\_  
(Closed Door Wholesaler Acct #)

- Other (if checked, please explain on the line) \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED/SIGNED FOR A CUSTOMER TO BE REVIEWED AS A POTENTIAL AZ CUSTOMER:**

\_\_\_\_\_  
(Signature of Director of Pharmacy) (Date)  
**Carson VanZant**

\_\_\_\_\_  
(Printed Name)  
**Chairman of Board**

\_\_\_\_\_  
(Job Title)

\_\_\_\_\_  
(Effective Date)  
**(380) 782-3353**

\_\_\_\_\_  
(Phone #)

\_\_\_\_\_  
(Fax #)

\_\_\_\_\_  
(Facility Name)  
**Mangum Regional Medical Center**

\_\_\_\_\_  
(Address)  
**1 Wickersham Drive**

\_\_\_\_\_  
(City, State, Zip)  
**Mangum Oklahoma 73554**

\_\_\_\_\_  
(DEA #)  
**FM7151777**

\_\_\_\_\_  
(HIN#)  
**730710IF2**

\_\_\_\_\_  
(e-mail address – if available)  
**kmartinez@chmcok.com**

Please return completed form to: [Membership@astrazeneca.com](mailto:Membership@astrazeneca.com)  
Note: This change will be effective 10 days from receipt by AstraZeneca.

**GPO/BUYING GROUP DESIGNATION FORM**

TO: Mangum Regional Medical Center Cohesive Healthcare Management  
(Company Name)

RE: \_\_\_\_\_  
(Contract Name) (Supplier Internal Contract Number)

FOR: \_\_\_\_\_  
(Product Category)

GPO: PREMIER HEALTHCARE ALLIANCE, L.P.  
(GPO Affiliation)

Please be advised that this Member chooses to use Products covered under the contract referenced above. Please take steps necessary to ensure this Member receives correct contract pricing.

Designated Authorized Distributor\*: AmerisourceBergen

Branch Location: \_\_\_\_\_ Account #: \_\_\_\_\_

Member Name\*: Mangum Regional Medical Center

Address\*: 1 Wickersham Drive

City, State, Zip\*: Mangum Oklahoma 73554 Telephone\*: (580) 782-3353

Authorized By (Print Name)\*: Carson VanZant

E-Mail Address\*: kmartinez@chmcok.com

Signature\*: \_\_\_\_\_

Title\*: Chairman of Board

Date\*: \_\_\_\_\_ DEA or HIN#\*: FM7151777 730710IF2

Member Facility Type\*: Acute Hospital

Approval/effective date\* for above Member: \_\_\_\_\_

**\*Indicates required field**

Return completed form to:

BTG International (attn. Com Ops Strategic Contracting)  
Street Address: 300 Four Falls Corporate Center, Suite 300  
300 Conshohocken State Road  
West Conshohocken, PA, 19428-2998 USA  
Fax: 610 943 6018 ( Attention: Com Ops Strategic Contracting)  
Email: [rebates@btgplc.com](mailto:rebates@btgplc.com)



**Group Declaration – New Premier Member**

Dear Customer:

To comply with contract requirements and ensure proper pricing is in place prior to placing orders, it is Baxter Healthcare Corporation's policy that you purchase our products through only one GPO contract.

By signing this document, you are indicating that **Premier Purchasing Partners, L.P.** is your preferred GPO to purchase Baxter Healthcare Corporation's Multisource Pharmaceuticals, Anesthesia & Critical Care products, as well as the wholesaler(s) you use, if applicable. If a wholesaler is not designated, Baxter Healthcare Corporation will not be responsible for any price adjustments that may be required since the information was not supplied.

**Please return your response either by mail to the address above, via fax at 224-270-3881 or by email to [RoundLake MD ACC Membership@baxter.com](mailto:RoundLake_MD_ACC_Membership@baxter.com).**

Sincerely,

Baxter Membership Team

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Please complete the information below for Multisource Pharmaceuticals, Anesthesia & Critical Care products:

**Premier Member Name:** Mangum Regional Medical CenterCohesive Healthcare Management

**Address:** 1 Wickersham Drive

**City, ST, Zip Code:** Mangum Oklahoma73554

**Baxter Account No.:** \_\_\_\_\_

**Customer DEA No.:** FM7151777 730710IF2

**Former Group Affiliation:** Premier

- **Primary Wholesaler** AmerisourceBergen
- **Secondary Wholesaler** \_\_\_\_\_

\_\_\_\_\_  
Signature of Premier Member

Carson VanZant

Print Name

kmartinez@chmcok.com

Email Address

\_\_\_\_\_  
Date

Chairman of Board

Title

**PREMIER HEALTHCARE ALLIANCE, L.P.**  
**PREMIER AMENDMENT #45 (ELI LILLY AMENDMENT #41) TO GROUP**  
**PURCHASING AGREEMENT - PHARMACEUTICALS**

**Attachment 3 to the Forty-First Amendment**

**Exhibit J-1: Eli Lilly and Company Group Purchasing Organization Declaration Form**

**Legal Name of Member:** Mangum Regional Medical Center Cohesive Healthcare Management

To be valid, form must be completed by an authorized individual employed by the Member.

**Address:** 1 Wickersham Drive

**City, State, Zip Code:** Mangum Oklahoma 73554

**Phone #:** (580) 782-3353 **Pharmacy HIN:** 730710IF2

**Pharmacy DEA #:** FM7151777

**Class of Trade ("COT"):** Please check the box(es) below that best describes your Institution or the Institution you serve. Consult the COT definitions on pg 2 for further detail.

**Acute Care:**

- |   |  |
|---|--|
| <input type="checkbox"/> Acute Care Hospital (Employee Pharmacy <input type="checkbox"/> )            | <input type="checkbox"/> System Affiliated Closed Door Outpatient Clinic |
| <input type="checkbox"/> Acute Care Children's Hospital (Employee Pharmacy <input type="checkbox"/> ) | <input type="checkbox"/> System Affiliated Surgery Center                |
| <input type="checkbox"/> Long Term Acute Care Hospital (LTACH)  |  |

**Alternate Care:**

- Long Term Care Facility

**Group Purchasing Organization ("GPO") Selection Declaration:**

By signing this document, Institution is authorizing Lilly to change its group purchasing affiliation. Institution is selecting or changing its GPO selection for buying Lilly Products through a group purchasing agreement ("GPO Agreement") between Lilly and GPO. All discount programs available with Current GPO Affiliation will be terminated upon receipt and acceptance by Lilly of this Declaration Form.

Current GPO Affiliation: Premier New GPO Affiliation: PREMIER HEALTHCARE ALLIANCE, L.P.

**GPO Requested Pricing Effective Date:** \_\_\_\_\_

Lilly will use the GPO Affiliation Effective Date to calculate pricing eligibility. Pricing eligibility will begin on the first (1st) or the fifteenth (15th) of a month based on the date that Lilly receives the Dec Form from the GPO. The Declaration Form must be received by Lilly at least fifteen (15) days prior to the proposed GPO Affiliation Effective Date; if not, pricing eligibility will begin the next occurring first (1st) or the fifteenth (15th) of the month that is at least fifteen (15) days prior to the date Lilly receives the completed Declaration Form.

Institution hereby represents and warrants to Lilly that it shall only utilize Lilly Products purchased under the GPO Agreement for its "OWN USE" as that term is used in Abbott Laboratories vs. Portland Retail Druggists Association, Inc., 96 S.Ct. 1305 (1976). Additionally, the above-named Institution acknowledges that Lilly will only recognize its affiliation with one GPO in relation to discount and/or rebate pricing of its Products.

Institution acknowledges its obligation to comply with all applicable laws and regulations regarding the purchase of Products under this Agreement. Institution is hereby informed that there may be an obligation to report discounts to the Department of Health and Human Services or applicable state agency. See United States Code of Regulations, Vol. 42, Part 1001 and Sec. 1001.952 (h) (1), (3). Institution agrees to forgo all other discounts for the same Products. Institution hereby recognizes that, should any discount be provided by Lilly to Institution in error, Lilly is hereby authorized to invoice Institution to collect any discount provided in error to Institution. Institution agrees to pay such invoice within thirty (30) days of receipt of an invoice. Institution reserves the right to review all information used by Lilly in determining the amount of discounts provided in error. Institution agrees to allow Lilly and/or its auditor to have access to any information in Institution's control that relates to Lilly Products necessary to audit GPO within the limits imposed by the GPO Agreement.

**Current GPO Affiliation Programs:**

For any Letter of Commitment or Letter of Participation (hereinafter referred to collectively as "LOC") executed by Institution for a discount program offered through Institution's Current GPO Affiliation, the discount pricing available under the LOC shall remain effective; provided however, (i) the same discount program for the same Lilly Product must be available through the Institution's New GPO Affiliation for the same Class of Trade, (ii) Institution must be eligible for participation in the same discount program for the same Lilly Product under New GPO Affiliation's GPO Agreement with Lilly; (iii) Institution agrees by signature below to comply with all terms and conditions of the New GPO Affiliation's discount program; and, (iv) in the event that Institution has executed an LOC for a discount program that is not available with the Institution's New GPO Affiliation, LOC for Institution will be terminated upon receipt and acceptance by Lilly of this GPO Declaration Form.

## Chairman of Board

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Authorized Representative of Institution  
(Signature)

**Carson VanZant**

---

Authorized Representative of Institution  
(Printed Name)

---

Title of Authorized Representative

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Date of Signature

*Lilly retains the sole right to determine eligibility of Institution signing this Declaration Form.  
Retail pharmacies are not eligible for pricing pursuant to this GPO Agreement.*

*GPO must send Completed Form to Eli Lilly and Company at [GPOinfo@lilly.com](mailto:GPOinfo@lilly.com). Declarations sent to [GPOinfo@lilly.com](mailto:GPOinfo@lilly.com) directly from Premier Members will not be accepted.*

### **Acute Care Class of Trade Definitions:**

**Acute Care Hospital:** A hospital facility whose purpose is to provide immediate or short-term (acute) care in an inpatient setting (operating 365 days per year 24 hours per day and listed in the American Hospital Association Directory). Pharmaceuticals are dispensed under the direction of a registered pharmacist and the pharmacy is NEITHER owned NOR operated by any federal, city, state, or county government. A hospital in this Class of Trade may purchase products either through a Group Purchasing Organization (GPO), through a wholesaler/distributor, or directly from the manufacturer.

**Acute Care Children's Hospital:** A hospital facility servicing only minors whose purpose is to provide immediate or short-term (acute) care in an inpatient setting (operating 365 days per year 24 hours per day and listed in the American Hospital Association Directory). Pharmaceuticals are dispensed under the direction of a registered pharmacist and the pharmacy is NEITHER owned NOR operated by any federal, city, state, or county government. A hospital in this Class of Trade may purchase products either through a Group Purchasing Organization (GPO), through a wholesaler/distributor, or directly from the manufacturer.

**Long Term Acute Care Hospital (LTACH):** Any Medicare-participating hospital with an average length of stay exceeding 25 days that is not otherwise classified as a rehabilitation or psychiatric hospital designed to provide extended medical and rehabilitation care for patients who are clinically complex and have multiple acute or chronic conditions. LTACH's differ from nursing home/sub-acute programs in that their patients are much more acutely ill, often critically ill, and require more specialized treatment programs and intensive nursing interventions that are generally not available within sub-acute programs. Services for such facilities may include, but are not limited to, ventilation weaning programs, chronic respiratory care, rehabilitation and medical, post-operative, and pain and wound management services. There is to be clear separation of ownership from a host hospital for the LTACH hospital within a hospital model. Long Term Care Facilities do not fall within this class of trade definition.

**System Affiliated Closed Door Outpatient Clinic:** A closed door (pharmacy is closed to access by the general public and does not compete with retail trade) outpatient facility dedicated to the provision of various forms of treatment which maintains a separate pharmacy from a hospital. This facility will have a unique HIN/DEA from the hospital. Such facilities operate during set business hours (not 24 hours per day). Examples include drug rehab clinics, alcohol treatment centers. Patients receiving care at this facility are associated with the facility's hospital system.

**System Affiliated Surgery Center:** A closed door (pharmacy is closed to access by the general public and does not compete with retail trade) outpatient facility, other than a physician's office, where surgical services are provided on an ambulatory basis which maintains a separate pharmacy from a hospital. This facility will have a unique HIN/DEA from the hospital. Such facilities operate during set business hours (not 24 hours per day). Patients receiving care at this facility are associated with the facility's hospital system.

### **Alternate Care Class of Trade Definitions:**

**Long Term Care Facility:** Residential care facilities providing active patient care (skilled and non-skilled) over an extended period of time (generally greater than thirty (30) days) in an attempt to achieve the goals of treatment, rehabilitation and discharge; and/or residential assisted-living facilities that combine housing, personalized supportive services and health care designated to meet the individual needs of persons in need of assistance with the activities of daily living; and/or behavioral health facilities that provide active patient care over an extended period of time (residential, non-residential, or a hybrid model) where individuals receive all pharmacy services at the behavioral health facility. In each case, patient care services are not based in the patient's home (ie/ home health). Such facilities (1) provide health care to residents or aligned patients and provide pharmaceutical products only to its own residents or aligned patients (ie/ closed door); (2) have an agreement with a long term care pharmacy to provide pharmacy consulting for and dispense pharmaceuticals to residents or aligned patients of such facilities, but not via mail order; and (3) have authorized a long term care pharmacy to provide access to Lilly Products for such facilities pursuant to the terms in the GPO Agreement, solely for "OWN USE" by such facilities (i.e. use or dispensing of Lilly Products by such facilities only for its own residents or aligned patients at such facilities and under no circumstances for use with or for resale to non-residents/non-aligned patients or any other person or party).



**EXHIBIT J**  
**GENENTECH USA OWN USE CERTIFICATION**

SELLER: Genentech USA, Inc.  
CONTRACT NUMBER: PPPH18GNT01  
PRODUCT CATEGORY: Brand Pharmaceuticals

**Participant Name:** Mangum Regional Medical Center  
**Address:** 1 Wickersham Drive  
**City, State, and Zip Code:** Mangum Oklahoma 73554  
**Class of Trade/Type of Provider:** Acute Hospital  
**DEA/HIN:** FM7151777 730710IF2  
**Contact Number/Email:** (580) 782-3353 kmartinez@chmcok.com

This Own Use Certification is executed and delivered pursuant to Section 4 of the Agreement. Capitalized terms not otherwise defined in this Own Use Certification shall have the meaning ascribed to such terms in the Agreement. Any alterations or modifications to this form will render it null and void.

I, Carson VanZant, hereby certify that I am the Chairman of Board of Mangum Regional Medical Center and that I am duly qualified and authorized to sign this Own Use Certification on behalf of the Participant, as specified above and all sites listed on Own Use Certification Attachment, as applicable. I hereby represent and certify as follows:

1. The information provided herein is true and correct;
2. Participant shall purchase Product through an "Authorized Wholesaler" meaning a distributor of Products that has a direct agreement with Genentech and whom has entered into arrangements for the distribution of Products;
3. The Products purchased by the Participant under the Agreement are only for dispensing to its patients in connection with, and on the same day for injectable or infused products, the provision of treatment and/or evaluation, and not for resale to any wholesaler, retailer, internet pharmacy, institution, physician or any other person or entity, within or outside of the U.S. Participant shall maintain records of its Product purchases and the circumstances of dispensing same to adequately reflect its compliance with the terms of this provision;
4. If Participant fails to observe the terms of this Own Use Certification, Genentech may, at its option, remove such Participant from the Agreement, or immediately cease providing the Discounts and/or Contract Prices made available to Participant under any agreement with Genentech, and Genentech may at its option, take other action that Genentech deems appropriate; and
5. Participant agrees to indemnify Genentech and hold Genentech harmless from and against any loss, damage, cost and expense, including attorneys' fees, with respect to any claim or demand arising from the breach of this Own Use Certification by Participant. This provision shall survive termination of the Agreement with Genentech.

IN WITNESS WHEREOF, the undersigned has executed and delivered this Own Use Certification as of the date set forth below.

Signature: \_\_\_\_\_ Title: Chairman of Board  
Print Name: Carson VanZant Date: \_\_\_\_\_

Please send this "Own Use Certification" form:

Via email to: [contractops@gene.com](mailto:contractops@gene.com)  
Via eFax to: (877) 228-1912  
Via Fax to: (650) 225-7715

Via Mail to: Genentech USA, Inc.  
Attention: Contract Operations  
1 DNA Way, Mailstop 312B  
South San Francisco, CA 94080

**EXHIBIT K  
LETTER OF COMMITMENT**

SELLER: Genentech USA, Inc.  
 CONTRACT NUMBER: PPPH18GNT01  
 PRODUCT CATEGORY: Brand Pharmaceuticals

**Participant Name:** Mangum Regional Medical Center  
**Address:** 1 Wickersham Drive  
**City, State, Zip Code:** Mangum Oklahoma 73554  
**Class of Trade/Type of Provider:** Acute Hospital  
**DEA/HIN:** FM7151777 730710IF2  
**Contact Number/Email:** (580) 782-3353 kmartinez@chmcok.com

Dear Carson VanZant:

Genentech USA, Inc. (“Genentech”), has entered into agreements with various group purchasing organizations for the purpose of setting the terms and conditions for purchase of certain Genentech Products by Participants under the applicable agreements. Currently, Genentech has your facility listed under more than one such group purchasing organization (“GPO”). Under the agreements we have with the GPO, Participants are allowed membership and participation with only one GPO for the purchase of Genentech Products. This “Letter of Commitment” is executed and delivered pursuant to the agreements between Genentech and the GPOs. In order to participate under the agreements in question, please identify below the GPO through which you shall be purchasing Genentech Products. You will be required to execute a new “Letter of Commitment” for any change in your affiliation to the GPO, and your new affiliation shall be effective forty-five (45) days after your request for such change has been made, subject to approval by Genentech. Capitalized terms not otherwise defined in this “Letter of Commitment” shall have the meaning ascribed to such terms in the applicable agreement between Genentech and the GPO in question.

I, Carson VanZant, hereby certify that I am the Chairman of Board of Mangum Regional Medical Center and that I am duly qualified and authorized to sign this Letter of Commitment form on behalf of the Participant as specified above, and all Participants listed on Attachment 1, incorporated herein to this Exhibit K by reference (collectively referred to herein as “Participants”). I hereby represent and certify as follows:

1. The information provided herein is true and correct;
2. Participants shall purchase all of its future requirements of Genentech Products solely through the GPO pursuant to the terms and conditions set forth in the agreement between Genentech and GPO;
3. Participants shall not purchase Genentech Products under any other affiliation agreement or arrangement and will not avail itself of the Discount and/or Contract Price terms for the purchase of Genentech Products pursuant to any other agreement;
4. If Participants fail to observe the terms of this “Letter of Commitment”, Genentech may, at its option, immediately cease providing the Discounts and/or Contract Prices made available to Participants under the agreement between Genentech and the GPO, or any other agreement with Genentech, and Genentech may at its option, take other action that Genentech deems appropriate; and
5. Participants shall terminate any other current affiliation agreement or arrangement to purchase Genentech Products prior to purchasing Genentech Products under the agreement between Genentech and GPO.

Previous GPO Affiliation	Current GPO Affiliation	Current Affiliation Start Date
Premier	PREMIER HEALTHCARE ALLIANCE, L.P	

IN WITNESS WHEREOF, the undersigned has executed and delivered this “Letter of Commitment” as of the date set forth below.

Signature: \_\_\_\_\_ Title: Chairman of Board  
 Print Name: Carson VanZant Date: \_\_\_\_\_

Please send this “Letter of Commitment” form to:  
 via email to: [contractops@gene.com](mailto:contractops@gene.com)  
 via mail to: Genentech USA, Inc.  
 Attention: Contract Operations  
 1 DNA Way, Mailstop 312B  
 Via eFax (877) 228-1912  
 Via fax to: (650) 225-7715  
 South San Francisco, CA 94080



# GROUP PURCHASING ORGANIZATION DESIGNATION AND BUSINESS TYPE ELIGIBILITY FORM

In order to access the available pricing and/or rebates under a Group Purchasing Organization (GPO) agreement, GSK requires that each eligible facility designate a GPO that currently has a contract with GSK. GSK permits each eligible facility to designate one Non Specialty GPO and multiple Specialty GPOs. If an eligible facility designates more than one Non Specialty GPO, GSK will consider the most recently received form notification as the operative Non Specialty GPO designation. GSK reserves the right to decline a facility's new or altered GPO designation.

Designations may be changed but will require thirty (30) days advance written notice to GSK. GSK reserves the right to refuse to extend a contract price to a facility that has failed to designate a GPO or does not meet contract eligibility requirements. A facility will be added to the designated GPO's contract(s) within thirty (30) days, if GSK determines that all contract eligibility requirements are met. (Declaration forms must be submitted for each location. "Blanket" declaration forms are not accepted.

## I. COMPLETE ALL REQUESTED INFORMATION: (PLEASE PRINT) (INCOMPLETE FORMS WILL NOT BE PROCESSED)

FACILITY NAME: Mangum Regional Medical Center

DEA# (Must be current & match facility address): FM7151777 HIN: 730710IF2

STATE LICENSE #: \_\_\_\_\_ DR NAME (if applicable): \_\_\_\_\_

DSH ELIGIBLE INPATIENT ACUTE FACILITY: YES  NO  DSH ID (if applicable): \_\_\_\_\_

PHYSICAL ADDRESS: 1 Wickersham Drive SUITE #: \_\_\_\_\_

CITY: Mangum STATE: Oklahoma ZIP: 73554

TELEPHONE #: (580) 782-3353 EMAIL: kmartinez@chmcok.com

## II. MUST DESIGNATE SOLE GROUP PURCHASING ORGANIZATION (GPO): PREMIER HEALTHCARE ALLIANCE, L.P.

## III. PLEASE CERTIFY (\*) TYPE OF BUSINESS FOR ABOVE FACILITY BY CHECKING ONE OF THE BOXES BELOW: (Business Type will be confirmed via research, telephone surveys, and site surveys, etc.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Ambulatory Surgical Center        | <input type="checkbox"/> Hospital Employee Pharmacy      | <input type="checkbox"/> On-site Outpatient Hospital Pharmacy             |
| <input type="checkbox"/> Combo Pharmacy Vaccines           | <input type="checkbox"/> Inpatient Treatment Center      | <input type="checkbox"/> Outpatient Clinic in a Hospital                  |
| <input type="checkbox"/> Correctional Facility Provider    | <input type="checkbox"/> Inpatient Psychiatric Facility  | <input type="checkbox"/> Physician Clinic/Doctor's Office                 |
| <input type="checkbox"/> Correctional Facility             | <input type="checkbox"/> Nursing Home Provider Pharmacy  | <input type="checkbox"/> Renal Dialysis Center                            |
| <input type="checkbox"/> Emergency Care/Urgent Care Center | <input type="checkbox"/> Nursing Home                    | <input type="checkbox"/> Retail   |
| <input type="checkbox"/> Health Clinic                     | <input type="checkbox"/> Occupational Med/Workman's Comp | <input type="checkbox"/> Specialty Pharmacy: Hospital/Health System Owned |
| <input type="checkbox"/> Home Health Care/Home Infusion    | <input type="checkbox"/> Oncology Clinic                 | <input type="checkbox"/> Student Health Center                            |
| <input type="checkbox"/> Hospice                           | <input type="checkbox"/> On-site Inpatient Hospital      | <input type="checkbox"/> Visiting Nurse                                   |

IV. (\*) CERTIFICATION: By signing below, Facility certifies, under penalty of perjury, that all of the above information is true and correct. Further, Facility certifies and agrees that (1) any GSK product purchased under any agreement shall be for its "Own Use," as defined by the United States Supreme Court in its opinions report at Abbott Laboratories et al. v. Portland Retail Druggist Association, Inc., 425 U.S. 1 (1976), and Jefferson County Pharmaceutical Association, Inc., v. Abbott Laboratories, et al., 103 S. Ct. 1011 (1983), and (2) GSK may, in its sole discretion, contact Facility's staff, and/or visit Facility's locations to verify that the above information is correct, and Facility agrees to provide such information to GSK as is reasonably necessary for GSK to make such a determination.

<u>Carson VanZant</u>	<u>Chairman of Board</u>	_____	_____
Print Name (Required)	Title (Required)	Signature (Required)	Date (Required)

Email Form to [uxx44702@gsk.com](mailto:uxx44702@gsk.com)

# A

## Product Program Letter of Participation – Appendix 1 to Schedule A

### REQUEST for GPO Affiliation Update

The purpose of this form is to request an update of the selected Group Purchasing Organization (GPO) for Product Programs. Terms and Conditions, including effective date of GPO affiliation updates, will be determined as set forth in Schedule B to the LOP. This form should be completed in its entirety and emailed to Merck Customer Contract Management ([lopprocessingcenter@merck.com](mailto:lopprocessingcenter@merck.com)) or submitted via other approved electronic means. Incomplete requests cannot be processed. If more space is required, please submit a list in MS Excel, formatted as below.

The newly selected GPO will be effective for all enrolled Product Programs. For entities in a Participant System, the newly selected GPO will be effective for all entities in the Participant System and for all enrolled Product Programs.

Mangum Regional Medical Center

Participant/Participant System Name: Cohesive Healthcare Management New GPO Name: PREMIER HEALTHCARE ALLIANCE, L.P.

Please update the GPO affiliation for the following entities/locations:

Entity/Location Name	Complete Address (Street address, City, State, Zip)	Director of Pharmacy	DEA or HIN	Name of Merck Representative
Mangum Regional Medical Center	1 Wickersham Drive	Carson VanZant	FM7151777	
	Mangum Oklahoma 73554		730710IF2	

By signing below, you are representing and warranting that you have authority to change the GPO affiliation for all entities/locations or Participant Systems listed:

Authorized Signature:	Printed Name: Carson VanZant	Title: Chairman of Board	Email address: kmartinez@chmcok.com	Date:
<b>For Merck CCM Use only</b>	Accepted and Approved by:	Date:	Merck Internal System Name:	Merck Internal System ID:

**Exhibit G-2**

**Novo Nordisk Inc. Group Declaration Form**

This document serves as a written confirmation of a primary group purchasing relationship with Novo Nordisk. Novo Nordisk only allows a single group (GPO) relationship, therefore, a primary GPO and Pharmacy Start Date is requested below. This document will supersede any prior GPO relationship.

Participating Member DEA/HIN#: FM7151777 730710IF2

Participating Member National Provider ID #: \_\_\_\_\_

Primary Wholesaler: AmerisourceBergen

Secondary Wholesaler: \_\_\_\_\_

Primary GPO: PREMIER HEALTHCARE ALLIANCE, L.P.

Former GPO: Premier

Pharmacy Start Date: \_\_\_\_\_

Participating Member Name: Mangum Regional Medical CenterCohesive Healthcare Management

Participating Member Address: I Wickersham Drive  
Mangum Oklahoma 73554

Contact Name: Carson VanZant

Title: Chairman of Board

Email: kmartinez@chmcok.com

Phone: (580) 782-3353

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Novo Nordisk shall have up to five (5) business days from the date the completed Group Declaration Form is received, to process any changes in primary GPO designation. Return completed forms to [nbidnotification@novonordisk.com](mailto:nbidnotification@novonordisk.com).

**PREMIER HEALTHCARE ALLIANCE, L.P. TO GROUP PURCHASING AGREEMENT  
PREMIER CONTRACT # PPPH18SNA01**

**MUST READ**

**SANOFI AVENTIS**

**MEMBER REQUIREMENTS TO BE ATTACHED TO PREMIER AGREEMENT**

New members and members switching GPOs, must send an email notification to Sanofi Aventis inclusive of the information required as noted below to: [membership.application@sanofi.com](mailto:membership.application@sanofi.com).

Participating Member Facility Name:	Mangum Regional Medical CenterCohesive Healthcare Management
Participating Member Address:	1 Wickersham Drive Mangum Oklahoma73554
Participating Member DEA/HIN#:	FM7151777 730710IF2
Participating Members Class of Trade:	Acute Hospital
Primary Wholesaler:	AmerisourceBergen
Secondary Wholesaler:	
Primary GPO:	PREMIER HEALTHCARE ALLIANCE, L.P.
Former GPO:	Premier
Pharmacy Start Date:	
Contact Name:	Carson VanZant
Contact Title:	Chairman of Board
Contact Email:	kmartinez@chmcok.com
Contact Phone:	(580) 782-3353
<b>If multiple sites, you must attach a list of facilities that will be purchasing Sanofi Aventis contracted products.</b>	

## CONTRACT COMMITMENT FORM (CCF)

General Information			
Note: Include Sanofi Pasteur Inc. customer number and name. If Sanofi Pasteur Inc. customer number is not known please provide business address and Drug Enforcement Administration (DEA) and/or Health Information Number (HIN) information below. If adding more than 5 accounts, please fill out the attached spreadsheet and include it in your request			
Sanofi Pasteur Inc. Customer Number	Business Name	Business Address (include city, state and zip code)	DEA and/or HIN Number
	Mangum Regional Medical Center	1 Wickersham Drive	FM7151777
		Mangum Oklahoma 73554	730710IF2

Group Affiliation
Buying Group or Contract Name: <u>PREMIER HEALTHCARE ALLIANCE, L.P.</u>
Note: <b>By signing this form, the customer is acknowledging that they will be removed from any other affiliation that they are currently associated with (i.e. GPO, PBGs, etc.).</b> Customer acknowledges that by choosing the above buying group, it will only be eligible to purchase products from Sanofi Pasteur Inc. under the contract which Sanofi Pasteur Inc. has with this buying group, and will not be eligible to purchase products under any other contract, which Sanofi Pasteur Inc. may have with other buying groups. A customer is limited to changing its designated buying group once every sixty (60) days.

Authorized Representative Name: Carson VanZant Chairman of Board

Authorized Representative Contact Information – phone/email: (580) 782-3353 kmartinez@chmcok.com

Authorized Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please fax completed form to 1-866-462-6737 or email to [membership.administration@sanofi.com](mailto:membership.administration@sanofi.com). Incomplete forms will not be accepted.

# PREMIERProRx®

## “Opt-Out” submission form for 340B GPO Statutory Prohibition

As a member of the Premier group purchasing organization and an automatic participant in the PREMIERPrRx® program, the facility designated below requests to NOT participate in (“Opt-Out of”) the PREMIERPrRx program’s automatic substitution logic and certifies that it meets the following criteria:

**Participates in the 340B program and is prohibited from purchasing items through a GPO in the outpatient setting (DSH, Children’s or freestanding cancer hospital only)**

By the signature below, the facility requests the Premier group purchasing organization to authorize the indicated prime vendor to deactivate and not make substitutions to products in the PremierProRx program whenever a brand or generically equivalent pharmaceutical product is ordered by the facility.

Once this request is approved by Premier, your prime vendor will be notified with a request to remove your facility from the PremierProRx program. It is important that Premier understands the purpose for this request. Please provide any details that support this request.

Details:

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<b>Date:</b>	_____	<b>Premier Entity Code:</b>	<u>834641</u>
Participating facility name:	<u>Mangum Regional Medical Center</u>		
DEA#:	<u>FM7151777</u>	HIN# (optional):	<u>730710IF2</u>
HRSA 340B Id #	_____		_____
Address:	<u>1 Wickersham Drive</u>	<u>Mangum</u>	<u>Oklahoma 73554</u>
Phone:	<u>(580) 782-3353</u>	Fax:	_____
E-mail:	<u>kmartinez@chmcok.com</u>		
Participating facility contact Name (printed):	<u>Carson VanZant</u>	<u>Chairman of Board</u>	_____
Participating facility contact Signature:	_____		
Prime vendor (Wholesaler):	<u>AmerisourceBergen</u>	Account number(s) (optional):	_____
Prime vendor distribution center:	_____		

**\*\* Be sure to provide all applicable account numbers with your prime vendor. Attach on separate list if necessary.**



**“Opt-Out” submission form for 340B GPO Statutory Prohibition**

A participating facility is required to provide 30 days written notice to Premier if it elects to opt out of the PremierProRx Product program.

**All standard wholesaler terms and conditions apply.**

Please e-mail (preferable) or fax completed and signed document to:

**PREMIERProRx® Program**

**Chris\_Johnson@premierinc.com**

**Attn: Chris Johnson**

**Fax: 704-733-2123**

**\*\* Communication in response to this request to NOT participate in the PREMIERProRx® program should follow no more than two (2) weeks after receipt of this request. If communication is not received after two (2) weeks, please follow-up via E-mail: [Chris\\_Johnson@premierinc.com](mailto:Chris_Johnson@premierinc.com), or call 704.816.5595.**

**Please note the defined eligibility or non-eligibility to participate in PREMIERProRx for 340B hospital accounts:**

<p>▶ <b>Eligible:</b></p> <ul style="list-style-type: none"> <li>• Non 340B facility</li> <li>• Rural referral</li> <li>• Sole community</li> <li>• Critical access</li> <li>• DSH in-patient that <u>CAN</u> separate inventory</li> <li>• Children’s in-patient that <u>CAN</u> separate inventory</li> <li>• Freestanding cancer in-patient that <u>CAN</u> separate inventory</li> </ul>	<p>▶ <b>Non-eligible:</b></p> <ul style="list-style-type: none"> <li>• DSH out-patient</li> <li>• Children’s out-patient</li> <li>• Freestanding cancer out-patient</li> </ul>
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